

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

July 17, 2013

Ms. Jennifer Combs-Wilber, Administrator
Green Mountain Nursing And Rehabilitation
475 Ethan Allen Avenue
Colchester, VT 05446

Dear Ms. Combs-Wilber:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 19, 2013**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN
Licensing Chief

PC:jl



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/19/2013
NAME OF PROVIDER OR SUPPLIER GREEN MOUNTAIN NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced onsite re-certification survey and investigation of 4 facility self-reports were completed by the Division of Licensing and Protection from 6/17/13 through 6/19/13. There were no regulatory violations related to the 4 self-reports. Regulatory violations related to the re-certification survey are cited as follows.	F 000	F281 <i>Assuming for the moment that the findings and the determination of the deficiency are accurate, without admitting or denying that they are, our proposed plan of correction is as follows:</i>	
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to assure that professional standards were met for the evaluation of the use and effectiveness of PRN (as needed) pain medications in relieving acute and chronic pain symptoms for 1 of 10 residents in the stage 2 survey sample [Resident #98]. Per 6/18/13 medical record review, Resident #98 is 85 years old and has diagnoses of acute and chronic low back and posterior leg pain related to spinal stenosis and sciatica. He/she has orders for a fentanyl 25 mcg topical patch (brand Duragesic), applied every 72 hours and three PRN (as needed) pain medications: Dilaudid 2 mg (generic, hydromorphone) 1 tablet by mouth every morning prior to getting out of bed as needed; APAP 325 mg (Acetaminophen) 2 tablets (650 mg) by mouth four times daily as needed and Tramadol 50 mg (brand, Ultram) 1 tablet every 6 hours as needed.	F 281	It is the policy of this facility to assure that professional standards are met for evaluating the use and effectiveness of PRN medications. Some of the ways we have done this for Resident # 98 is, in accordance with the physician and pharmacist reevaluate the need for PRN medications versus scheduled, develop PRN medication frequency parameters, and continue to reeducate staff on the importance of thorough and consistent documentation relating to the use and effectiveness of PRN medications. Completed 6/20/2013 All residents who have physician orders for PRN medications have a potential to be affected by this alleged deficient practice. To assure that this alleged deficient practice does not affect other residents the pharmacist has	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Jennifer Conroy-Welby Administrator 7/8/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	<p>Continued From page 1</p> <p>Per 6/18/13 review of Resident #98's 4/24/13 care plan for alteration in comfort related to a recent fall and spinal compression, with moderate to severe back and leg pain. The care plan calls for the resident to be medicated with PRN pain medication in the early morning to facilitate the start of his/her day; to promptly use medications when indicated and to monitor and record the effectiveness of drugs used to control pain.</p> <p>Per 6/18/19 review of the MAR (Medication Administration Record) for May and June 2013 (copied on 6/18/13 at 1:50 PM by the DON (Director of Nursing)), Resident #98 was administered Dilaudid 2 mg in the morning prior to getting out of bed on 28 of 29 days from 5/1-5/29/2013 (not given on 5/17/13) and on 16 of 18 days from 6/1-6/18/13 (not given 6/10 and 6/14/13). He/she was administered Tramadol 50 mg on 16 days from 5/1-5/29/2013 (5/1, 5/5, 5/6, 5/7, 5/8, 5/10, 5/14 and 5/19-5/27) and on 6 days from 6/1-6/18/13 (6/6, 6/7, 6/12, 6/14, 6/17 and 6/18/13). He/she was administered acetaminophen 650 mg on 14 days from 5/1-5/29/2013 (5/1, 5/2, 5/5, 5/7, 5/8, 5/11, 5/13 and 5/21-5/27/13) and on 8 days from 6/1-6/18/13 (6/6, 6/7, 6/10-6/12, 6/14, 6/17 and 6/18/13). On the medication cart with the MAR, there is an accompanying "PRN pain medication administration record and flow sheet," which has blocks to document the date, time, pre-pain scale (0-10), description and location of pain, intervention and treatment, post pain scale and time of assessment. Per record review, the PRN pain medication administration record was available for the dates 5/1-5/24/13 and 6/14-6/18/13; it was not available for the dates 5/25-6/13/13 (when a new flow sheet would</p>	F 281	<p>developed a report of all residents who have orders for PRN medications from this report, in accordance with the physician and pharmacist a plan of ongoing reevaluation for the need of PRN medications versus scheduled, development and evaluation of PRN medication frequency parameters, and continuing to reeducate staff on the importance of thorough and consistent documentation relating to the use and effectiveness of PRN medications has been done and will continue to be done through annual education programs as well as included in nurse orientation programs.</p> <p>To ensure the alleged practice does not occur, and procedure stays consistent we are taking the following measures:</p> <p>A quality Assurance evaluation has been implemented under the supervision of the QA committee, DON, and Administrator for three consecutive months then quarterly thereafter. This evaluation will include a systematic review of all residents with PRN physician orders. Documentation will be</p>	

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F 281	<p>Continued From page 2</p> <p>have been started) at the time of the survey and this was confirmed on 6/18/13 with the DON and nursing supervisor at 1:45 PM on 6/18/13. Per review of the PRN Pain Medication Administration Record and Flow Sheet and the MAR, there is documentation on 5/4 and 6/1/13 for the effectiveness of the use of Dilaudid PRN; there is documentation on 5/1, 5/5, 5/6, 5/7 5/14, 5/22 5/25, of the effectiveness of the use of Tramadol and documentation of the effectiveness of Acetaminophen on 5/1, 5/2, 5/5, 5/7, 5/11, 5/22, 5/25.</p> <p>Per 6/18/13 interview, the unit nursing supervisor agreed that there was not consistent documentation of PRN pain medication effectiveness and reported a need for an inservice regarding documentation. Per 6/18/13 1:50 PM interview with the DON, s/he also agreed that documentation for post pain medication assessments were incomplete.</p> <p>Reference: Lippincott Manual of Nursing Practice (9th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins.</p>	F 281	<p>audited for frequency of use and effectiveness; immediate action will be taken if warranted. Completion Date 07/12/2013 <i>F281 POC accepted 7/11/13 JHomer RN/PMC</i></p> <p>F282 <i>Assuming for the moment that the findings and the determination of the deficiency are accurate, without admitting or denying that they are, our proposed plan of correction is as follows:</i></p> <p>It is the policy of this facility to provide appropriate services to maintain or improve resident abilities with the highest practicable outcome in ambulation and activities of daily living. This policy is implemented with Resident #65 by offering a choice of ambulation according to care plan.</p> <p>Document ambulation program on LNA flow sheet including refusals. Nurse's documentation of why refusal occurred. Reevaluate from physical therapy and/or restorative program if decline in ambulation abilities occur.</p> <p>No refusals to be noted due to staff convenience.</p> <p>Completed 6/20/2013</p>	
F 282 SS=E	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and record review, the facility failed to implement the care</p>	F 282		

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F 282	<p>Continued From page 3</p> <p>plan for 1 of 25 residents in the stage 2 survey sample to ensure that appropriate services were provided to maintain or improve his/her abilities with the highest practicable outcome for ambulation and activities of daily living (Resident #65). The findings include:</p> <p>Per interview on 6/17/13 at 2:17 P.M., Resident #65, who is 93 years old and has diagnoses of impaired physical mobility related to syncope and falls and a history of an L5 (5th lumbar vertebrae) compression fracture, reported that there was not enough staff available for him/her to get a walk two times per day and that he/she has "been fussing about this for 6 months." On further interview on 6/19/13 at 10:25 AM, he/she stated, "Basically, the problem is that I can't walk by myself....I have complained to just about everyone that I am not taken for walks; told caregiver and nurse who gives me the medicine. They keep a record and know whether I walk or not."</p> <p>Per 6/19/13 review of Resident #65's MDS (Minimum Data Set), quarterly reviews dated 12/20/12 and 3/12/13, under functional status, Resident #65 is listed as needing extensive assistance for bed mobility, transfers and walking in his/her room. On the 3/12/13 functional status review, under the category walking in corridors, Resident #65 is listed as "highly involved in the activity" and that staff provide guided maneuvering of limbs and the resident requires 1 person assistance. On both reviews, the resident is listed as walking with an assistive device, not steady, and only able to stabilize with human assistance.</p>	F 282	<p>All residents who ambulate with assistance have a potential to be affected by this alleged deficient practice. To assure that this alleged deficient practice does not affect other residents, offer a choice of ambulation according to care plan. Document ambulation program on LNA flow sheet including refusals. Nurse's documentation of why refusal occurred. Reevaluate from physical therapy and/or restorative program if decline in ambulation abilities occur.</p> <p>No refusals to be noted due to staff convenience.</p> <p>To ensure the alleged practice does not occur, and procedure stays consistent we are taking the following measures:</p> <p>A quality Assurance evaluation has been implemented under the supervision of the QA committee, DON, and Administrator for three consecutive months then periodic audits thereafter. This evaluation will include a systematic review of all residents who ambulate with assistance including resident interview and documentation.</p>	07/12/2013

*F282 POC accepted 7/11/13
JHosmer RN/PMC*

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F 282	<p>Continued From page 4</p> <p>Per 6/18/13 medical record review, Resident #65's Care Plan related to physical mobility impairment (updated 6/18/13), lists the following goal, "Resident will maintain mobility AEB ambulating BID with a walker and Ax1 daily x 90 days" (AEB [as evidenced by], BID [twice daily], Ax1 [with assistance of 1 person] and x 90 days [for a period of 90 days]). The plan details include that Resident #65 is to avoid prolonged chair sitting; ambulate as resident desires with 1 assist and a walker with wheelchair following; and encourage ambulation BID: one time on day and evening shifts.</p> <p>Per 6/18/13 review of the LNA (licensed nursing assistant) care plan for Resident #65, under the section listed as "transfer/ambulation", the plan details the need for one person assistance and the use of a gait belt (safety belt connecting the resident and LNA when walking) and to ambulate BID with wheelchair following one time on both day and evening shifts.</p> <p>Per 6/18/13 review of the ADL (activities of daily living) flow sheet recorded by the LNA staff, for the month of May 2013, there were 22 out of 31 days on the 7-3 PM shift and 1 of 31 days on the 3-11 shift that ambulating in the corridor did not occur. During the month of June 2013, there were 4 of 18 days that ambulating in the corridor did not occur on the 7-3 shift. On 6/19/13 at 8:20 AM, the unit supervisor confirmed that the flow sheets indicated that Resident #65 did not walk 22 of 31 days in May 2013 on the 7-3 shift and 4 days in June on the 7-3 shift. On 6/19/13 8:28 AM, the DON (Director of Nursing) confirmed that same result.</p>	F 282	<p>F311</p> <p><i>Assuming for the moment that the findings and the determination of the deficiency are accurate, without admitting or denying that they are, our proposed plan of correction is as follows:</i></p> <p>It is the policy of this facility to deliver appropriate treatment and services to maintain or improve resident abilities as indicated by the comprehensive assessment to achieve and maintain the highest practicable outcome. This policy is implemented with Resident #65 by offering a choice of ambulation according to care plan as indicated by the MDS. Document ambulation program on LNA flow sheet including refusals. Nurse's documentation of why refusal occurred. Reevaluate from physical therapy and/or restorative program if decline in ambulation abilities occur. No refusals to be noted due to staff convenience.</p>	

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F 282	Continued From page 5 Per interview on 6/18/13 3:40 PM with the unit evening supervisor, she/he confirmed that the LNA care plan calls for the resident to ambulate twice daily, once on the day and once on the evening shift. She reported that she/he is aware that Resident #65 wants to maintain his activity level (by ambulating). Per 6/19/13 8:51 AM, interview with an LNA who has known Resident #65 for 3 years and regularly provides care, he/she reported walking is very important for this resident and he/she was aware that the resident has complained when s/he doesn't get to walk. He/she reported that the resident is scheduled to walk one time per day per shift, but the staff were "fighting for time" to help him walk daily. Per 6/19/13 review of nursing progress notes, for the month of May 2013, on 5/24/13, there is a late entry note written by the DON from a meeting that occurred with the resident on 5/17/13. The meeting was held to address how care was going and to address any concerns that the resident might be having. Resident #65 was documented as saying that he would like to walk more with staff. ADL care was also discussed. At the end of the note, the DNS wrote, will continue to monitor and follow up. There are no other nursing progress notes for the month of May 2013 that address ambulation.	F 282	Completed 6/20/2013 All residents who are indicated by the MDS to ambulate with assistance have a potential to be affected by this alleged deficient practice. To assure that this alleged deficient practice does not affect other residents, offer a choice of ambulation according to care plan. Document ambulation program on LNA flow sheet including refusals. Nurse's documentation of why refusal occurred. Reevaluate from physical therapy and/or restorative program if decline in ambulation abilities occur. No refusals to be noted due to staff convenience. To ensure the alleged practice does not occur, and procedure stays consistent we are taking the following measures:		
F 311 SS=E	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.	F 311	A quality Assurance evaluation has been implemented under the supervision of the QA committee, DON, and Administrator for three consecutive months then periodic audits thereafter. This evaluation will include a systematic review of all residents who ambulate with		

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F 311 Continued From page 6

This REQUIREMENT is not met as evidenced by:
Based on resident and staff interview and record review, the facility failed to ensure that 1 of 25 residents in the stage 2 survey sample, received appropriate treatment and services to maintain or improve his/her abilities as indicated by the comprehensive assessment to achieve and maintain the highest practicable outcome (Resident #65). The findings include:

Per interview on 6/17/13 at 2:17 P.M., Resident #65, who is 93 years old and has diagnoses of impaired physical mobility related to syncope and falls and a history of an L5 (5th lumbar vertebrae) compression fracture, reported that there was not enough staff available for him/her to get a walk two times per day and that he/she has "been fussing about this for 6 months." On further interview on 6/19/13 at 10:25 AM, he/she stated, "Basically, the problem is that I can't walk by myself...I have complained to just about everyone that I am not taken for walks, told caregiver and nurse who gives me the medicine. They keep a record and know whether I walk or not."

Per 6/19/13 review of Resident #65's MDS (Minimum Data Set), quarterly reviews dated 12/20/12 and 3/12/13, under functional status, Resident #65 is listed as needing extensive assistance for bed mobility, transfers and walking in his/her room. On the 3/12/13 functional status review, under the category walking in corridors, Resident #65 is listed as "highly involved in the activity" and that staff provide guided maneuvering of limbs and the resident requires 1

F 311

assistance including resident interview and documentation.
Completion Date 07/12/2013

*F311 POC accepted 7/11/13
JHomer RN / PNC*

F329

Assuming for the moment that the findings and the determination of the deficiency are accurate, without admitting or denying that they are, our proposed plan of correction is as follows:

It is the policy of this facility to make sure that each resident remains free from unnecessary drugs.

Some of the ways we have done this for Resident # 45 is, in accordance with the physician and pharmacist reevaluate the need for PRN medications versus scheduled, develop PRN medication frequency parameters, and continue to reeducate staff on the importance of thorough and consistent documentation relating to the use and effectiveness of PRN medications.

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F 311	<p>Continued From page 7</p> <p>person assistance. On both reviews, the resident is listed as walking with an assistive device, not steady, and only able to stabilize with human assistance.</p> <p>Per 6/18/13 medical record review, Resident #65's Care Plan related to physical mobility impairment (updated 6/18/13), lists the following goal, "Resident will maintain mobility AEB ambulating BID with a walker and Ax1 daily x 90 days" (AEB [as evidenced by], BID [twice daily], Ax1 [with assistance of 1 person] and x 90 days [for a period of 90 days]). The plan details include that Resident #65 is to avoid prolonged chair sitting; ambulate as resident desires with 1 assist and a walker with wheelchair following; and encourage ambulation BID: one time on day and evening shifts.</p> <p>Per 6/18/13 review of the LNA (licensed nursing assistant) care plan for Resident #65, under the section listed as "transfer/ambulation", the plan details the need for one person assistance and the use of a gait belt (safety belt connecting the resident and LNA when walking) and to ambulate BID with wheelchair following one time on both day and evening shifts.</p> <p>Per 6/18/13 review of the ADL (activities of daily living) flow sheet recorded by the LNA staff, for the month of May 2013, there were 22 out of 31 days on the 7-3 PM shift and 1 of 31 days on the 3-11 shift that ambulating in the corridor did not occur. During the month of June 2013, there were 4 of 18 days that ambulating in the corridor did not occur on the 7-3 shift. On 6/19/13 at 8:20 AM, the unit supervisor confirmed that the flow sheets indicated that Resident #65 did not walk 22 of 31</p>	F 311	<p>Completed 6/20/2013</p> <p>All residents who have physician orders for PRN medications have a potential to be affected by this alleged deficient practice. To assure that this alleged deficient practice does not affect other residents the pharmacist has developed a report of all residents who have orders for PRN medications from this report, in accordance with the physician and pharmacist a plan of ongoing reevaluation for the need of PRN medications versus scheduled, development and evaluation of PRN medication frequency parameters, and continuing to reeducate staff on the importance of thorough and consistent documentation relating to the use and effectiveness of PRN medications has been done and will continue through annual education and in nurses new employee orientation.</p> <p>To ensure the alleged practice does not occur, and procedure stays consistent we are taking the following measures:</p>	

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F 311	<p>Continued From page 8</p> <p>days in May 2013 on the 7-3 shift and 4 days in June on the 7-3 shift. On 6/19/13 8:28 AM, the DON (Director of Nursing) confirmed that same result.</p> <p>Per interview on 6/18/13 3:40 PM with the unit evening supervisor, she/he confirmed that the LNA care plan calls for the resident to ambulate twice daily, once on the day and once on the evening shift. She reported that she/he is aware that Resident #65 wants to maintain his activity level (by ambulating).</p> <p>Per 6/19/13 8:51 AM, interview with an LNA who has known Resident #65 for 3 years and regularly provides care, he/she reported walking is very important for this resident and he/she was aware that the resident has complained when s/he doesn't get to walk. He/she reported that the resident is scheduled to walk one time per day per shift, but the staff were "fighting for time" to help him walk daily.</p> <p>Per 6/19/13 review of nursing progress notes, for the month of May 2013, on 5/24/13, there is a late entry note written by the DON from a meeting that occurred with the resident on 5/17/13. The meeting was held to address how care was going and to address any concerns that the resident might be having. Resident #65 was documented as saying that he would like to walk more with staff. ADL care was also discussed. At the end of the note, the DNS wrote, will continue to monitor and follow up. There are no other nursing progress notes for the month of May 2013 that address ambulation.</p>	F 311	<p>A quality Assurance evaluation has been implemented under the supervision of the QA committee, DON, and Administrator for three consecutive months then quarterly thereafter. This evaluation will include a systematic review of all residents with PRN physician orders will be analyzed and documented for frequency of use and effectiveness, immediate action will be taken if warranted.</p> <p>Completion Date 07/12/2013</p> <p><i>F329 POC accepted 7/11/13 - J. Kosmer RN / AMC</i></p> <p>F387</p> <p><i>Assuming for the moment that the findings and the determination of the deficiency are accurate, without admitting or denying that they are, our proposed plan of correction is as follows:</i></p> <p>It is the policies of this facility to assure that physician visits are done according to regulatory guidelines.</p>	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329	Resident #9 physician visits are currently up to date. A memo has been sent to physician reminding	

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F 329	<p>Continued From page 9</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that 1 of 10 residents (Residents # 45) in the applicable stage 2 sample were free from unnecessary drugs. Findings include:</p> <p>1. Per record review on 6/18/13 at 10:45 A.M., Resident #45 had physician orders for 3 "as needed" (PRN) medications that did not have</p>	F 329	<p>him of the guidelines relating to SNF resident visits. Completed 6/20/2013</p> <p>All residents residing in this facility have a potential to be affected by this alleged deficient practice. The following procedure is in place:</p> <p>All physicians who provide services at GMNH will have a letter of reminder relating to visit guidelines. Physician will be reminded of upcoming visit requirements by phone and fax. If physician fails to meet visit requirement prior to due date Administrator will contact physician for notification. If physician does not meet visit requirement within the 10 day grace period Medical Director will attempt to contact physician for a courtesy call reminding him/her of visit requirements and visit resident.</p> <p>A quality Assurance evaluation has been implemented under the supervision of the QA committee, DON, and Administrator for three consecutive months then quarterly thereafter. This evaluation will</p>	

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F 329	Continued From page 10 adequate parameters for their use. The orders were for Risperdal (anti-psychotic), Immodium (anti-diarrheal) and Ibuprofen (analgesic). All of these medications were ordered as BID (twice daily) with no indication as to how much time was allotted between doses. Per interview with a unit medication nurse on 6/18/13 at 11:04 AM, the nurse stated that s/he would have to contact the doctor to determine when the medications could be given. On 6/18/13 at 11:15 AM, the Unit Manager (UM) confirmed that the 3 medications needed clarification as to when they could be given. The UM also stated that the pharmacy consultant usually picks up on issues like this, had visited on 5/22/13 and had not "picked it up this time".	F 329	include a systematic review of physician visits. Immediate action will be taken if warranted. Completion Date 07/12/2013 <i>F329 POC accepted 7/11/13 -JAsmerrck/ANC</i>		
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to assure that the physician visited each resident at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter for 1 of 25 residents in the stage 2	F 387	F482 <i>Assuming for the moment that the findings and the determination of the deficiency are accurate, without admitting or denying that they are, our proposed plan of correction is as follows:</i> It is the policies of this facility to assure that the pharmacist reviews each drug regimen on a monthly basis. Resident #45's medication orders have been reassessed by pharmacist and physician for irregularities concerning the PRN medications, implementing frequency parameters. Completed 6/20/2013 All residents who have physician orders for PRN medications have a potential to be affected by this alleged deficient practice.		

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F 387 Continued From page 11 sample. (Resident #9) Findings Include:

Per Medical Record review, Resident #9 (who was admitted on 1/11/11 with diagnoses including Diabetes, Chronic Obstructive Pulmonary Disease, Hypertension, Delusional Disorder and Dementia) was not seen by the attending physician every 60 days after the first 90 days. The resident was seen by his/her physician on 8/2/12, 11/2/12, 2/22/13 and 5/19/13. The Unit Manager confirmed on 6/18/13 at 2:30 PM that the physician did not visit every 60 days as required.

F 428 483.60(c) DRUG REGIMEN REVIEW, REPORT SS=D IRREGULAR, ACT ON

The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, The facility failed to ensure that the consultant Pharmacist reported any medication irregularities to the attending physician for 1 of 10 applicable residents in the stage 2 sample (Residents # 45). Findings include:

1. Per record review on 6/18/13 at 10:45 A.M.,

F 387 To assure that this alleged deficient practice does not affect other residents the pharmacist has developed a report of all residents who have orders for PRN medications from this report, in accordance with the physician and pharmacist a plan of ongoing reevaluation for the need of PRN medications versus scheduled, development and evaluation of PRN medication frequency parameters, and continuing to reeducate staff on the importance of thorough and consistent documentation relating to the use and effectiveness of PRN medications has been done and will continue through annual education and in nurses new employee orientation.

To ensure the alleged practice does not occur, and procedure stays consistent we are taking the following measures:

A quality Assurance evaluation has been implemented under the supervision of the QA committee, DON, and Administrator for three consecutive months then quarterly thereafter. This evaluation will

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F 428	Continued From page 12 Resident # 45 had physician orders for 3 "as needed" (PRN) medications that did not have adequate parameters for their use. The orders were for Risperdal (anti-psychotic), Immodium (anti-diarrheal) and Ibuprofen (analgesic). All of these medications were ordered as BID (twice daily) with no indication as to how much time was allotted between doses. Review of the Pharmacy consultant records showed that the consultant had visited on 5/22/13 and had not noted any irregularities.	F 428	include a systematic review of all residents with PRN physician orders, and a review of pharmacy consult forms to ensure that the PRN orders have frequency parameters. Completion Date 07/12/2013 <i>F428 POC accepted 7/11/13 JHsmernk/ame</i>	
F 514 SS=E	483 75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	F 514 <i>Assuming for the moment that the findings and the determination of the deficiency are accurate, without admitting or denying that they are, our proposed plan of correction is as follows:</i>	
			It is the policies of this facility to assure that the clinical records on each resident have sufficient documentation regarding the use and effectiveness of PRN pain medications. Resident # 98 has a PRN medication documentation sheet each month. Staff have been reeducated on the importance of thorough documentation relating to the effectiveness of PRN medications and specifically PRN	

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F 514	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to assure that the clinical record for 1 of 10 residents in the stage 2 survey sample [Resident #98] had complete documentation regarding the use and effectiveness of PRN pain medications in relieving acute and chronic pain symptoms.</p> <p>Per 6/18/13 medical record review, Resident #98 is 85 years old and has diagnoses of acute and chronic low back and posterior leg pain related to spinal stenosis and sciatica. He/she has orders for a fentanyl 25 mcg topical patch (brand Duragesic), applied every 72 hours and three PRN (PRN, defined by medterms.com as "when necessary" or as needed) pain medications: Dilaudid 2 mg (generic, hydromorphone) 1 tablet by mouth every morning prior to getting out of bed as needed; APAP 325 mg (Acetaminophen) 2 tablets (650 mg) by mouth four times daily as needed and Tramadol 50 mg (brand, Ultram) 1 tablet every 6 hours as needed.</p> <p>Per 6/18/13 review of Resident #98 's 4/24/13 care plan for alteration in comfort related to a recent fall and spinal compression, with moderate to severe back and leg pain; the care plan calls for the resident to be medicated with PRN pain medication in the early AM to facilitate the start of her day; to promptly use medications when indicated and to monitor and record the effectiveness of drugs used to control pain.</p> <p>Per 6/18/19 review of the MAR (Medication Administration Record) for May and June 2013</p>	F 514	<p>pain medications in relieving acute and chronic pain symptoms. Completed 6/20/2013 All resident of this facility who have physician orders for PRN medications and specifically pain medications have a potential to be affected by this alleged deficient practice.</p> <p>Staff have been reeducated on the importance of thorough documentation relating to the effectiveness of PRN medications and specifically pain medications in relieving acute and chronic pain symptoms.</p> <p>PRN medication sheets will be changed on a monthly basis, pain sheets to be revised to include documentation of q shift pain and prn pain medication usage.</p> <p>A quality Assurance evaluation has been implemented under the supervision of the QA committee, DON, and Administrator for three consecutive months then quarterly thereafter. This evaluation will include a systematic review of all residents with PRN pain medications and documentation.</p> <p>Completion Date 07/12/2013</p>	

F514 POC accepted 7/11/13 JH-smierRN/PMC

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F 514 Continued From page 14
(copied on 6/18/13 at 1:50 PM by the DON (Director of Nursing), Resident #98 was administered Dilaudid 2 mg in the morning prior to getting out of bed on 28 of 29 days from 5/1-5/29/2013 (not given on 5/17/13) and on 16 of 18 days from 6/1-6/18/13 (not given 6/10 and 6/14/13). He/she was administered Tramadol 50 mg on 16 days from 5/1-5/29/2013 (5/1, 5/5, 5/6, 5/7, 5/8, 5/10, 5/14 and 5/19-5/27) and on 6 days from 6/1-6/18/13 (6/6, 6/7, 6/12, 6/14, 6/17 and 6/18/13). He/she was administered acetaminophen 650 mg on 14 days from 5/1-5/29/2013 (5/1, 5/2, 5/5, 5/7, 5/8, 5/11,5/13 and 5/21-5/27/13) and on 8 days from 6/1-6/18/13 (6/6, 6/7, 6/10-6/12, 6/14, 6/17 and 6/18/13). On the medication cart with the MAR, there is an accompanying "PRN pain medication administration record and flow sheet," which has blocks to document the date, time, pre-pain scale (0-10), description and location of pain, intervention and treatment, post pain scale and time of assessment. Per record review, the PRN pain medication administration record was available for the dates 5/1-5/24/13 and 6/14-6/18/13; it was was not available for the dates 5/25-6/13/13 (when a new flow sheet would have needed to be started) at the time of the survey and this was confirmed on 6/18/13 with the DON and nursing supervisor at 1:45 PM on 6/18/13. Per review of the PRN Pain Medication Administration Record and Flow Sheet and the MAR, there is documentation on 5/4 and 6/1/13 for the effectiveness of the use of Dilaudid PRN; there is documentation on 5/1, 5/5, 5/6, 5/7 5/14, 5/22 5/25, of the effectiveness of the use of Tramadol and documentation of the effectiveness of Acetaminophen on 5/1, 5/2, 5/5, 5/7, 5/11,5/22, 5/25.

F 514

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F 514	Continued From page 15	F 514		
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Per 6/18/13 interview, the unit nursing supervisor agreed that there was not consistent documentation of PRN pain medication effectiveness and reported a need for an inservice re documentation. Per 6/18/13 1:50 PM interview with the DON, she also agreed that documentation for post pain medication assessments were incomplete.